

Seasonal Flu and Pneumonia Vaccination 2014-2015 Insurance Information Form

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Information about the person receiving the vaccine (please print): *Required Fields Name: (Last, First, MI)* Date of Birth: * Sex: (Circle)* Age* Male Female Month Day Year Street Address:* City:* Zip:* Phone:* (State: * Insurance Information: Include the whole member ID number and any letters that are part of that number Name of Insurance Company:* Member ID Number:* Group ID Number: (if available) Name of Secondary Insurance Member ID Number:* Group ID Number: (if available) If person receiving vaccine is not the subscriber, please complete the following: Subscriber's Name: (Last, First, MI)* Subscriber's Date of Birth: * Sex: (Circle)* Male Female Month Day Year Subscriber's Street Address:* (If different from address above) State:* Phone:* City:* Zip: * Patient Relationship to Subscriber: (circle)* Spouse Child Other: For children 18 years of age and younger: ☐ Is enrolled in Medicaid (includes MassHealth, HMOs etc. if enrolled through Medicaid) ☐ Does not have health insurance ☐ Is American Indian (Native American) or Alaska Native Has health insurance and is not American Indian (Native American) or Alaska Native I give permission for myself (or my child) to receive the vaccine, for vaccination information to be included in the Massachusetts Immunization Information System (MIIS)* and for my insurance company to be billed. *Please see reverse side for MIIS details.

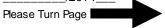
For Clinic/Office Use Only:

(Signature of patient, parent or legal quardian)

Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given 2014
□ IIV3				0.5	Yes No	Yes No	IM	R Arm L Arm	8/19/14	
□ IIV4				0.5	Yes No	Yes No	IM	R Arm L Arm	8/19/14	
□ LAIV4	Medimmune			0.20	Yes No	Yes	Intranasal	NA	8/19/14	
PPV23	Merck			0.5	Yes	No	IM	R Arm L Arm	10/06/09	

Clinic	Site Name/Address:	Arlington Board of Health, 27 Maple Street, Arlington, MA	02476

MDPH Provider PIN#: 11828 Vaccine Administrator Initials: _____ Date of Service: _____/2014___





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The following questions will determine if you (or your child) can receive the 2014-2015 Seasonal Flu Vaccine. Please mark YES or NO for each question.

A. If you answer "YES" to one or more of the four questions, you (or your child) will <u>not</u> be able to receive the flu vaccine. If you answer "NO" to the following questions you (or your child) will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your healthcare provider.

Information about the person receiving the vaccine		
Do you have a serious allergy to eggs?	1	1
2. Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	†	1
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	1	1
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe mus weakness) within 6 weeks after receiving a flu vaccine?	scle ↑	1

B. Your answers to the following questions help us determine which vaccine is best for you (or your child).

Information about the person receiving the vaccine		
 Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? 	†	1
2. If your child is 2-4 years of age, has a healthcare provider told you that your child wheezing or asthma within the last 12 months?	hild †	1
3. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	u †	1
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	1	1
5. Are you pregnant?	↑	1
6. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	1	1
7. Are you currently taking anti-viral therapy (e.g., Tamiflu, Relenza, etc.)?		

Please be sure to complete all of the information on the front side of this form. Thank you.

^{*}Providers are required by law to report your immunizations to the Massachusetts Immunization Information System (MIS) (M.G.L. c.111, Section 24M). For more information, please visit the MIS website at www.mass.gov/dph/miis, or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.